

ATTACHMENT B

TRANSITION PERCENTAGES FOR CAPITAL PAYMENT AMOUNTS

MAJOR TEACHING HOSPITALS

	<u>Major Teaching Peer Group Amounts</u>	<u>Own Case-mix Adjusted Capital Cost @ Case</u>	
1996	25.0 %	75.0 %	(1994)
1997	50.0	50.0	(1995)
1998	75.0	25.0	(1996)
1999	100.0	0.0	(1997)

LARGE URBAN HOSPITALS

	<u>Large Urban Peer Group Amount</u>	<u>Non-Major Teaching Peer Group Amount</u>	<u>Own Case-mix Adjusted Capital Cost @ Case</u>
1996	25.0 %	0.0 %	75.0 %
1997	37.5	12.5	50.0
1998	37.5	37.5	25.0
1999	0.0	100.0	0.0

ALL-OTHER HOSPITALS

	<u>All-Other Peer Group Amount</u>	<u>Non-Major Teaching Peer Group Amount</u>	<u>Own Case-mix Adjusted Capital Cost @ Case</u>
1996	25.0 %	0.0 %	75.0 %
1997	37.5	12.5	50.0
1998	37.5	37.5	25.0
1999	0.0	100.0	0.0

NOTES: Major Teaching: FTE Interns and Residents/Average Daily Census) > 0.20

Large Urban: Kanawha, Putnam, and Cabell counties

TN No. 96-01

Supersedes

TN No. 89-02

Approval Date

OCT 09 1996

Effective Date

JAN 01 1998

4.19 Payments for Medical and Remedial Care and Services
ATTACHMENT 4.19-A-1

Inpatient Hospital Services - Disproportionate Share
Hospitals

Methodology to adjust payments for inpatient services furnished by disproportionate share hospital.

A. Definitions: A disproportionate share hospital is a hospital licensed by the State of West Virginia Department of Health and Human Resources and which meets one of the following criteria:

1. The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals in the State which is the ratio of Medicaid inpatient days in a cost reporting period to the total number of the hospital's inpatient days in that period. Inpatient days include each day in which an individual (including a newborn) is an inpatient in the hospital, whether in a specialized ward or awaiting placement elsewhere.
2. The hospital's low-income utilization rate exceeds 25 percent. The hospital's low-income utilization rate is the sum of:
 - a. The fraction (expressed as a percentage)-
 - (1) The numerator of which is the sum (for a period) of (a) the total revenues paid the hospital for patient services under the Medicaid State Plan and (b) the amount of the cash subsidies for patient services received directly from State and local governments, and
 - (2) The denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and
 - b. A fraction (expressed as a percentage) -
 - (1) The numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in the period, less the portion of any cash

4.19 Payments for Medical and Remedial Care and Services
ATTACHMENT 4.19-A-1 (Continued)

Inpatient Hospital Services - Disproportionate Share
Hospitals

subsidies described in a. (1) above in the period reasonably attributable to inpatient hospital services, and

- (2) The denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under (b)(1) above shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under the approved Medicaid State Plan).

3. Hospitals with high Medicaid inpatient utilization defined as meeting the following criteria:

- a. During the hospital's cost reporting period the hospital provided in excess of 3,000 Medicaid inpatient days of service, or

- b. For the same hospital cost reporting period, the sum of the following factors equalled or exceeded eight percent:

- (1) Total Medicaid inpatient days divided by total inpatient days, and

- (2) The ratio of Medicare Part A days attributable to SSI recipients or the SSI inpatient days divided by the total Medicare covered days. This information can be obtained from the Medicare intermediary or, since the SSI/Medicare percentages are determined by HCFA on a federal fiscal year basis, hospitals have the option of determining the SSI/Medicare percentage based upon data from their own cost reporting periods (which must be reconciled to the most recent

4.19 Payments for Medical and Remedial Care and Services
ATTACHMENT 4.19-A-1 (Continued)

Inpatient Hospital Services - Disproportionate Share Hospitals

Federal fiscal years); and

- (3) Total days of care provided to eligible Medicaid inpatients in excess of "covered days" divided by total Medicaid inpatient days.
4. The hospital is an acute care or psychiatric hospital owned by the State of West Virginia and operated by the Department of Health and Human Resources or a rehabilitation hospital owned by the State of West Virginia and operated by the Department of Education; or Hospitals designated as CRITICAL ACCESS HOSPITALS, (also known as ESSENTIAL ACCESS COMMUNITY HOSPITALS as defined in Section 4.19-A.3.a. of the State Plan), by the West Virginia Department of Health and Human Resources, Bureau of Public Health. New hospitals or hospitals offering expanded services may submit eligibility data for their most recently completed quarter.
5. In addition to the above criteria, all hospitals must meet the following:
 - a. All hospitals offering non-emergency obstetrical services as of 12/22/87 must have two obstetricians with staff privileges. These physicians must agree to provide obstetrical services to Medicaid recipients. In the case of hospitals located in a rural area, "obstetrician" may include any physician with staff privileges who performs non-emergency obstetrical services at the hospital.
 - b. All hospitals must have a one percent or greater Medicaid Utilization Rate (MUR).
- B. Payment Adjustment: Hospitals qualifying As disproportionate share hospitals (DSH) under this plan (as noted in A above) will receive a payment adjustment in addition to others made for services. The Commissioner of the Single State Agency shall allocate funds for disproportionate share hospital payments. The hospitals will be notified sixty (60) days prior to the end of each quarter as to the total quarterly allotment. The allotment of funds will be paid as follows:

TN No. 99-02

Supersedes

TN No. 95-07

Approval Date JUN 28 1999

Effective Date

4/1/99

HCFA ID: _____

4.19 Payments for Medical and Remedial Care and Services
ATTACHMENT 4.19-A-1 (Continued)

Inpatient Hospital Services - Disproportionate Share
Hospitals

1. MINIMUM DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT POOL - The Commissioner of the Single State Agency will allocate an additional payment amount to hospitals qualifying under A.1. or A.2. and A.5. above. The payment adjustments will equal the lesser of:
 - a. The hospital's quarterly approved claims times the percentage by which the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals qualified under this Section, or
 - b. One fourth of the hospital's annual cost limit as defined in Section B.4.
2. NON-STATE OWNED HOSPITAL PAYMENT POOL - The Commissioner of the Single State Agency may allocate an additional payment amount to hospitals qualifying under A.1. through A.3. and A.5. above. The allocation will not exceed the Federal Allotment of Funds less Section B.1., B.3. and B.5. payments.
 - a. The Commissioner will establish the following Non-State Owned Hospital Groups for the payment of funds allotted under this Section.
 - (1) Small Hospital Group - Hospitals qualifying under Sections A.1. through A.3. and A.5. above with less than one hundred licensed acute care beds (does not include distinct part nursing facility beds) shall be paid ten percent (10%) of the total funds allocated in this Section.
 - (2) Large Hospital Group - Hospitals qualifying under Sections A.1. through A.3. and A.5. above with one hundred or more licensed acute care beds (does

4.19 Payments for Medical and Remedial Care and Services
ATTACHMENT 4.19-A-1 (Continued)

Inpatient Hospital Services - Disproportionate Share
Hospitals

not include distinct part nursing facility beds) shall be paid fifteen percent (15%) of the total funds allocated in this Section.

- (3) Eligibility Group - Hospitals qualifying under Sections A.1. through A.3. and A.5. above shall be paid seventy-five percent (75%) of the total funds allocated in this Section.

- b. The payment factors for the Small Hospital Group, Large Hospital Group and Eligibility Group will be computed at the beginning of each State Fiscal Year. The factors will be based on each hospital's financial statements, cost reports and related data for its fiscal year ended during the calendar year preceding the start of the State Fiscal Year. New hospitals or hospitals with significant organizational changes, may submit survey data for their most recent quarter. The financial statements must be prepared in accordance with Generally Accepted Accounting Principles (GAAP). The payment factors will be computed as follows:

- (1) The Small Hospital Payment Factor will be calculated for each qualifying hospital in Section B.2.a.(1). The factor will be the sum of the following:

- (a) Inpatient Factor. The payment factor shall be the sum of the following:

(i) Five percent.

(ii) Two percent for every one percent or fraction thereof that the Medicaid inpatient days as a percent of total inpatient days for the

4.19 Payments for Medical and Remedial Care and Services
ATTACHMENT 4.19-A-1 (Continued)

Inpatient Hospital Services - Disproportionate Share
Hospitals

hospital exceeds five
percent.

- (b) Obstetrical Services (OB) Factor.
For qualifying hospitals providing
non-emergency obstetrical care
where the hospital's ratio of
total Medicaid deliveries of
newborn babies to total deliveries
is in excess of thirty-nine
percent, the adjustment factor
will be the sum of the following:

(i) Five percent.

(ii) One-half of one percent for
every one percent or fraction
thereof that the ratio of
Medicaid deliveries to total
deliveries exceeds thirty-
nine percent.

- (c) Uncovered Day Factor. One percent
for every percent or fraction
thereof that the ratio of total
Medicaid days to total "covered"
Medicaid days exceeds one hundred
percent.

- (2) The Large Hospital Payment Factor will
be calculated for each qualifying
hospital under Section B.2.a.(2). The
factor will be the sum of the
following:

- (a) Inpatient Factor. The payment
factor shall be the sum of the
following:

(i) Five percent.

(ii) Two percent for every one
percent or fraction thereof
that the Medicaid inpatient
days as a percent of total

4.19 Payments for Medical and Remedial Care and Services
ATTACHMENT 4.19-A-1 (Continued)

Inpatient Hospital Services - Disproportionate Share
Hospitals

inpatient days for the
hospital exceeds five
percent.

- (b) Obstetrical Services (OB) Factor. For qualifying hospitals providing non-emergency obstetrical care where the hospital's ratio of total Medicaid deliveries of newborn babies to total deliveries is in excess of thirty-nine percent, the adjustment factor will be the sum of the following:

(i) Five percent.

(ii) One-quarter of one percent for every one percent or fraction thereof that the ratio of Medicaid deliveries to total deliveries exceeds thirty-nine percent.

- (c) Uncovered Day Factor. One percent for every percent or fraction thereof that the ratio of total Medicaid days to total "covered" Medicaid days exceeds one hundred percent.

- (3) Eligibility Payment Factor. The eligibility payment factor is calculated by dividing each hospital's total operating expenses by the total operating expenses for all qualifying hospitals under Section B.2.a.(3).

c. The quarterly payment adjustment for hospitals qualifying under this Section is calculated as follows:

- (1) The small hospital adjustment factor will be multiplied by the hospital's quarterly Medicaid approved inpatient claims and prorated for all eligible

4.19 Payments for Medical and Remedial Care and Services
ATTACHMENT 4.19-A-1 (Continued)

Inpatient Hospital Services - Disproportionate Share
Hospitals

hospitals against the total dollars allocated to the small hospital group.

- (2) The large hospital adjustment factor will be multiplied by the hospital's quarterly Medicaid approved inpatient claims and prorated for all eligible hospitals against the total dollars allocated to the large hospital group.
- (3) The eligibility payment adjustment is calculated by multiplying each hospital's eligibility factor by the total dollars allocated to the eligibility group.
- (4) The quarterly payment adjustment for hospitals within the small, large and eligibility groups shall be the lessor of:
 - (a) The sum of each hospital's adjustments for (1) or (2) plus (3) above, or
 - (b) One fourth of the hospital's annual cost limit as defined in Section B.4 less the hospital's payment under Section B.1. above. If the payment amount calculated within this subsection is less than subsection (a) above, the difference between (a) and (b) will be re-allocated to the remaining hospitals (in accordance with Section B.2. above) where (b) is greater than (a).

3. STATE OWNED OR OPERATED HOSPITAL POOL - The Commissioner of the Single State Agency will allocate an additional payment amount to hospitals qualifying under Sections A.4 and A.5. above. The allocation will be equal to the cost limit for all hospitals qualifying

4.19 Payments for Medical and Remedial Care and Services
ATTACHMENT 4.19-A-1 (Continued)

Inpatient Hospital Services - Disproportionate Share
Hospitals

under this Section less Section B.1. payments. Qualifying hospitals will receive a quarterly payment adjustment which will equal one-fourth of the annual cost limit less Section B.1. payments.

4. ANNUAL COST LIMIT - The annual sum of each hospital's Section B.1, B.2. or B.3. payments will be limited to the cost of services to Medicaid patients (Inpatients and Outpatients) less the amount paid by West Virginia Medicaid under the NON-DSH payment provisions plus the cost of services to uninsured patients (Inpatients and Outpatients) less any cash payments made by or for them. The uninsured (for the purposes of this plan) are those patients without third party coverage. The cost of services to uninsured patients may not include patients with third party coverage in whole or in part.
 - a. An estimated cost limit will be computed at the beginning of each State Fiscal Year. The estimated cost limit will be based on each hospital's financial data for its fiscal year ended during the calendar year preceding the start of the State Fiscal Year. The estimated cost limit may be adjusted to reflect anticipated changes in cost and/or revenues.
 - b. A tentative and/or final annual cost limit will be calculated from data contained within each hospital's tentative and/or final HCFA-2552 cost report and supplemental schedules as required. A tentative and/or final DSH cost settlement will be made in addition to other cost settlements.
5. THE SUM OF SECTION B.1., B.2. and B.3. PAYMENTS WILL NOT EXCEED THE TOTAL FEDERAL ALLOTMENT OF FUNDS.

State West Virginia

ATTACHMENT 4.19-A-2

4.19 Payments for Medical and Remedial Care and Services

ATTACHMENT 4.19-A-2

INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUAL UNDER 22 YEARS OF AGE

Payment is based on a cost-base retrospective reimbursement system determined by applying the standards, cost reporting periods, cost reimbursement principles, and method of cost apportionment used under title XVIII of the Social Security Act, prior to the Social Security Amendments of 1983 (Section 601, Public Law 98-21). That is, payment is to be determined by the current Medicare Principles methodology of cost-based reimbursement.

Interim payments are made based on a percentage of charge for all in-state facilities as well as out-of-state facilities that have a high utilization rate. A per diem rate will be utilized for low volume out-of-state facilities based on the most recent cost information submitted by the facility. Low volume out-of-state facilities are defined as those who serve only four to five Medicaid recipients on an annual basis. Interim payments will be reconciled to allowable cost by State agency staff using their first full fiscal years beginning after April 1, 1995. For purposes of determining initial payment rates for psychiatric services for individuals under age 22, exceptions to the Medicare payment principles will not be applied. Tests of reasonableness, appropriateness, and necessity, as demonstrated in Medicare Regulations, will be applied to the determination of these factors pending audit and final settlement.

Final payment and settlement will be made subsequent to audit by the State agency of filed cost reports and supporting financial documentation, as detailed in Medicare Regulation. Final payment determinations will not consider the incentive and cost sharing amounts provided for in the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (Public Law 97-248).

TN No. 95-14 APPROVAL DATE JUN 04 1996 EFFECTIVE DATE APR 01 1995